Indiana State Department of Health
PHHS Block Grant
Preventive Health and Health Services Block Grant

Work Plan

Original Work Plan for Fiscal Year 2011
Submitted by: Indiana
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Contents **Page**

Executive Summary

This is Indiana's application for the Preventive Health and Human Services (PHHSBG) for Federal Fiscal Year 2011. The PHHSBG is administered by the United States Department of Health and Human Services through its administrative agency, the Centers for Disease Control and Prevention (CDC) in accordance with the Public Health Service Act, Sections 1901-1907, as amended in October, 1992 and Section 1910A as amended in October 1996. The Indiana State Department of Health is designated as the principal state agency for the allocation and administration of the PHHSBG within the State of Indiana.

Funding Assumptions
The total award for the FFY 11 PHHSBG is $1,692,929.00. This amount is based upon the draft allocation table distributed for FFY 11 by the CDC.

Proposed Allocation for FY 2011
PHHS Block Grant dollars are allocated to those health areas that have no other source of state or federal funds, or, wherein combined, state and federal funds are insufficient to address the extent of the public health problem. FFY 2011 funding priorities are as follows:

Program	Health Objective	Funds
Chronic Disease Prevention & Control	12-1	$350,000
Direct Assistance	23-2	$100,000
Injury and Violence Prevention	15-7	$100,000
Office of Women's Health	23-17	$100,000
Oral Health	21-8	$ 75,000
Public Health Performance Management	23-8	$619,030
Sexual Assault Services	15-35	$148,899
State Health Data Center	23-2	$200,000

Impacting other health objectives:

- Disability and Secondary Conditions 6-12
- Educational/Community-Based Programs 7-2, 3, 5, 6, 7, 9, 10, 11, 12
- Health Communication 11-1, 4, 5
- Injury and Violence Prevention 15-7, 8, 10
- Maternal, Infant, & Child Health 16-14
- Nutrition and Overweight 19-1, 2, 3, 5, 6, 8, 9, 16
- Oral Health 21-16
- Physical Activity and Fitness 22-1, 2, 6, 13, 14, 15
- Public Health Infrastructure 23-3, 4, 5, 9, 10, 11, 12, 15
- Tobacco Use 27-1, 2, 3, 4, 5, 6, 7, 11, 12, 13

As established by the Public Health Services Act, Section 1905(d), the Indiana PHHSBG Advisory Committee makes recommendations regarding the development and implementation of the State Plan/Application. The Advisory Committee reviewed and approved the programs listed above for funding for FFY 2011.

Funding Rationale: Under or Unfunded, Data Trend

Statutory Information

Advisory Committee Member Representation:

College and/or university, County and/or local health department, Federal government , Hospital or health system, State health department, State or local government

Dates:

Public Hearing Date(s):	**Advisory Committee Date(s):**
	10/12/2010
	12/7/2010

Current Forms signed and attached to work plan:

Certifications: Yes
Certifications and Assurances: Yes

Budget Detail for IN 2011 V0 R0	
Total Award (1+6)	$1,692,929
A. Current Year Annual Basic	
1. Annual Basic Amount	$1,544,030
2. Annual Basic Admin Cost	$0
3. Direct Assistance	($100,000)
4. Transfer Amount	$0
(5). Sub-Total Annual Basic	$1,444,030
B. Current Year Sex Offense Dollars (HO 15-35)	
6. Mandated Sex Offense Set Aside	$148,899
7. Sex Offense Admin Cost	$0
(8.) Sub-Total Sex Offense Set Aside	$148,899
(9.) Total Current Year Available Amount (5+8)	$1,592,929
C. Prior Year Dollars	
10. Annual Basic	$0
11. Sex Offense Set Aside (HO 15-35)	$0
(12.) Total Prior Year	$0
13. Total Available for Allocation (5+8+12)	$1,592,929

Summary of Funds Available for Allocation	
A. PHHSBG $'s Current Year:	
Annual Basic	$1,444,030
Sex Offense Set Aside	$148,899
Available Current Year PHHSBG Dollars	$1,592,929
B. PHHSBG $'s Prior Year:	
Annual Basic	$0
Sex Offense Set Aside	$0
Available Prior Year PHHSBG Dollars	$0
C. Total Funds Available for Allocation	$1,592,929

Summary of Allocations by Program and Healthy People 2010 Objective

Program Title	Health Objective	Current Year PHHSBG $'s	Prior Year PHHSBG $'s	TOTAL Year PHHSBG $'s
Chronic Disease Prevention and Control	12-1 Coronary Heart Disease	$350,000	$0	$350,000
Sub-Total		**$350,000**	**$0**	**$350,000**
Injury Prevention Program	15-13 Unintentional injury deaths	$100,000	$0	$100,000
Sub-Total		**$100,000**	**$0**	**$100,000**
Office of Women's Health	23-17 Population-based prevention research	$75,000	$0	$75,000
Sub-Total		**$75,000**	**$0**	**$75,000**
Oral Health Program	21-8 Dental sealants	$75,000	$0	$75,000
Sub-Total		**$75,000**	**$0**	**$75,000**
Public Health Performance Management	23-8 Competencies for public health workers	$644,030	$0	$644,030
Sub-Total		**$644,030**	**$0**	**$644,030**
Sexual Assault Services	15-35 Rape or attempted rape	$148,899	$0	$148,899
Sub-Total		**$148,899**	**$0**	**$148,899**
State Health Data Center	23-2 Public health access to information and surveillance data	$200,000	$0	$200,000
Sub-Total		**$200,000**	**$0**	**$200,000**
Grand Total		**$1,592,929**	**$0**	**$1,592,929**

State Program Title: Chronic Disease Prevention and Control

State Program Strategy:

Program Goal: The Indiana State Department of Health (ISDH) – Chronic Disease Prevention and Control division (CDPC) seeks to reduce the disparities and overall burden of chronic disease in Indiana. The Cardiovascular Health Program within the CDPC seeks to monitor and reduce cardiovascular health (CVH) disparities and overall burden in Indiana.

Program Priorities:

· **National**

o Increase control of high blood pressure primarily in adults and older adults
o Increase control of high blood cholesterol primarily in adults and older adults
o Increase knowledge of signs and symptoms for heart attack and stroke, and the importance of calling 911
o Improve emergency response
o Improve quality of heart disease and stroke care
o Eliminate health disparities in terms of race, ethnicity, gender, geography, or socio-economic status

· **State (2010-11):**

o Improve surveillance, analysis, and communication of CVH indicators and risk factors in Indiana
o Lead a coordinated statewide effort to improve CVH outcomes
o Advance evidence based public health strategies to improve cardiovascular health in community settings through systems-level change, policy, and environmental change

Primary Strategic Partnership(s):

· Internal: Diabetes Prevention and Control Program, Comprehensive Cancer Control Program, Healthy Communities, Division of Nutrition and Physical Activity

· External: American Heart Association, Indiana Stroke Prevention Task Force, Indiana Minority Health Coalition, Indiana Tobacco Prevention and Cessation

Role of PHHSBG Funds: Strengthen state ability to provide statewide data surveillance and analysis, public health systems coordination and technical assistance to communities in reducing Indiana's CVH burden

Evaluation Methodology:

The CVHP follows national evaluation guidelines as put forth by the CDC Framework for Evaluation and the CDC Evaluation Guide for State Heart Disease and Stroke Programs. An annual evaluation plan will be utilized to monitor processes and impact of program activities. Products during the first funding year include a statewide CVH Burden Report, as well as communication tools for statewide partners and communities. Statewide CVH Coalition partner initiatives will be tracked through online and interview assessments; CVHP communication strategies will also be evaluated using records of meetings and other reports. The CVHP will work closely with the Chronic Disease Healthy Communities Program to assess local communities for readiness to implement policies, systems-level changes, or environmental changes (PSE) that would improve CVH outcomes. These assessments will then be utilized in evaluating the effectiveness of PSE strategies implemented in these communities. Expanded data from the Behavioral Risk Factor Surveillance System (BRFSS) specific to CVH will assist in measuring change in outcomes.

State Program Setting:

State health department

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0
Total FTEs Funded: 0.00

National Health Objective: HO 12-1 Coronary Heart Disease

State Health Objective(s):

Between 01/2011 and 12/2011, Increase data surveillance, analysis, and communication for CVH indicators and risk factors in Indiana to include an annual CVH Burden Report, Fact Sheet on CVH Health Disparities, and Fact Sheet on CVH and Risk Factors

Baseline:

No current CVH data analysis, burden reports, or other data reports

Data Source:
ISDH records; BRFSS, hospital discharge/mortality data, EMS data

State Health Problem:

Health Burden:
There are several risk factors associated with heart attack and stroke. Of great concern are diabetes, smoking, high blood pressure, high cholesterol, physical inactivity, and poor nutrition. The 2009 BRFSS showed that 16% of diabetics had a heart attack and 8.7% had stroke. Of those who smoke, 5.1% reported having a heart attack and 3% reported stroke. Indiana ranked 18th in the nation for hypertension. with 28.5% of adults reporting having high blood pressure in 2003-07 (BRFSS). The 2009 BRFSS showed that 11.2% of adults with high blood pressure reported having a heart attack while 5.9% reported having stroke. Of those with high cholesterol, 11% reported having a heart attack and 5.4% reported having stroke. The 2009 BRFSS also showed that decreased physical activity and poor nutrition with less than 5 servings of fruits and vegetables increases the chances of having heart attack and stroke in the population.

Target Population:
Number: 6,500,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 6,500,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male

Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: US Census Bureau; BRFSS

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Model programs include:
- Pawtucket Heart Health Program
- Minnesota Heart Health Program
- Stanford Five-City Project

Resources include:
- American Heart Association Guide for Improving Cardiovascular Health at the Community Level
- Examples of Successful Community-Based Public Health Interventions (State-by-State) – www.healthyamericans.org
- CDC: A Public Health Action Plan to Prevent Heart Disease and Stroke

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $350,000
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Start-up
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
75-99% - Primary source of funding

ESSENTIAL SERVICES – OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 1 – Monitor health status

Objective 1:
Evaluate the prevalence and mortality of Heart Disease and Stroke
Between 01/2011 and 12/2011, Program Epidemiologist will analyze **2** separate sets of data relating to prevalence and mortality of heart disease and stroke.

Annual Activities:
1. Evaluate the prevalence and mortality of Heart Disease and Stroke
Between 01/2011 and 12/2011, The Cardiovascular Health Program will collect, analyze and communicate data related to cardiovascular disease (heart disease and stroke) in the general population. The data will include an assessment of health disparities and risk factors associated with cardiovascular disease. State data will be compared to the national data and communicated to a variety of audiences – including external partners, public health professionals, general public, and policy-makers as appropriate

Objective 2:
Collect and analyze additional data related to cardiovascular health in Indiana
Between 01/2011 and 12/2011, Program Epidemiologist will collect **4** sets of data relating to hospitalization, emergency medical services, Medicaid/Medicare services, and state-added BRFSS survey questions.

Annual Activities:

1. Collect and analyze Hospitalization and Emergency Medical Services data

Between 01/2011 and 12/2011, The Cardiovascular Health Program will expand its database. Hospitalization and Emergency Medical Services data will be collected and analyzed to increase our information on the burden of heart disease and stroke in the state

2. Collect and analyze Medicaid/Medicare and additional BRFSS data

Between 01/2011 and 12/2011, The Cardiovascular Health Program will expand Indiana's BRFSS survey questionnaire by adding new cardiovascular questions to the BRFSS Survey. The Program will also collect and analyze relevant Medicaid/Medicare data to determine the economic impact of cardiovascular disease in the state. This will advance our understanding of the burden of cardiovascular disease in the state so we may best implement evidence-based strategies to address this burden.

Objective 3:

Develop Cardiovascular Health Burden Report

Between 01/2011 and 12/2011, Program Epidemiologist will develop **1** Cardiovascular Health Burden Report.

Annual Activities:

1. Develop Cardiovascular Health Burden Report

Between 01/2011 and 12/2011, The Cardiovascular Health Program will develop a burden report for heart disease and stroke in Indiana, so that the scope and magnitude of the problem can be described as it applies to the state. The report will also describe the disparity of burden across various socioeconomic groups.

Essential Service 2 – Diagnose and Investigate

Objective 1:

Investigate current distribution of heart disease and stroke in the community

Between 01/2011 and 12/2011, Program Epidemiologist will evaluate **1** distribution pattern of heart disease and stroke at the community level.

Annual Activities:

1. Investigate current distribution of heart disease and stroke in the community

Between 01/2011 and 12/2011, The Cardiovascular Health Program will investigate and analyze the pattern and trend for cardiovascular diseases, stroke and related risk factors at the local level. This will help with implementing policy, systems change, and environmental change needed to bring about improved cardiovascular health in communities.

Essential Service 4 – Mobilize Partnerships

Objective 1:

Establish a statewide coalition

Between 01/2011 and 12/2011, Program Coordinator; Policy and Environmental Analyst will establish **1** statewide coalition of critical partners in cardiovascular health.

Annual Activities:

1. Establish a statewide coalition

Between 01/2011 and 12/2011, The Cardiovascular Health Program will develop a statewide cardiovascular health coalition. This will be done by identifying potential partners, regions and communities involved with heart disease and stroke. The coalition will identify leaders, formulate work groups and establish guiding principles for the coalition to function. The work groups will identify gaps in partnership, recruit partners of

influence in cardiovascular health, and will work collaboratively to improve the performance of public health functions related to cardiovascular diseases and stroke.

Objective 2:

Develop State Cardiovascular Health Plan

Between 01/2011 and 12/2011, All Program Staff will develop **1** State Cardiovascular Health Plan.

Annual Activities:

1. Develop State Cardiovascular Health Plan

Between 01/2011 and 12/2011, The Cardiovascular Health Program will begin the following activities to ready the statewide coalition for development of a state cardiovascular health plan: conduct assessments to determine what current evidence-based public health initiatives related to cardiovascular disease are being implemented by coalition partners and communities; analyze cardiovascular health public health data and present this to the coalition partners in order to demonstrate areas of needed focus in improving cardiovascular health; and prepare the Coalition to identify SMART objectives and evidence-based public health strategies which will improve the burden of cardiovascular disease in Indiana over a five-year period of time. A critical part of this process is building and maintaining communications with coalition partners; to this end, the CVHP will implement a communications plan for the coalition that will include web-based forums, meetings, online public health assessments and evaluations, other web-based tools, publish periodic newsletters, and establish a coalition listserv.

Objective 3:

Evaluate public health, policy, and environmental change strategies

Between 01/2011 and 12/2011, All program staff will evaluate **1** set of public health, policy, and environmental change strategies.

Annual Activities:

1. Evaluate public health, policy, and environmental change strategies

Between 01/2011 and 12/2011, The Cardiovascular Health Program will develop and maintain communication with the Coalition on policy and environmental change strategies for the improvement of heart disease and stroke burden in the state. This will emphasize heart-healthy policies, physical and social environmental change, and disparities elimination (e.g., based on geography, gender, race or ethnicity, or socioeconomic status). The CVHP will also develop population-based public health strategies to increase public awareness of heart disease and stroke prevention, the signs and symptoms of heart disease and stroke, and the need to call 9–1–1.

State Program Title: Injury Prevention Program

State Program Strategy:

Goal: To develop an Injury Prevention Program for the State of Indiana that will ultimately lead to a reduction in the number of preventable injuries and deaths.

Health Priorities: The Indiana State Department of Health does not currently have an organized Injury Prevention Program. The agency does publish an annual Fireworks Injury Report and, every 3 years, the Indiana Injury Report. However, contractors are generally utilized to produce these reports. Dr. Paul Halverson, President of ASTHO, has issued a challenge for states to increase efforts to reduce preventable injuries and death. The ISDH would like to prioritize the development of an Injury Prevention Program for its citizens.

Primary Strategic Partners:

Internal:	**External:**
Epidemiology Resource Center	Indiana Child Fatality Review Team
Vital Records	Coroner's Assocation
Maternal and Child Health	Riley Hospital
State Health Data Center	Family & Social Services Agency
Trauma Program	Department of Natural Resources
	Injury Prevention Task Force
	School Safety Advisory Committee
	Suicide Prevention Task Force

Evaluation Methodology: The development of a core Injury Prevention Program that will ultimately lead to acquisition of data, analysis, and development of appropriate activities.

State Program Setting:

State health department

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Injury Prevention Division Director
State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 1
Total FTEs Funded: 1.00

National Health Objective: HO 15-13 Unintentional injury deaths

State Health Objective(s):

Between 01/2011 and 12/2011, develop a comprehensive injury and violence prevention program at the state health department that provides focus and direction, coordinates and finds common ground among the many prevention partners, and maximizes injury and violence prevention resources.

Baseline:
The Indiana State Department of Health (ISDH) does not have a comprehensive injury and violence prevention program responsible for providing leadership and coordination for injury and violence prevention in the state.

Data Source:
An assessment of the Indiana State Department of Health Injury Prevention Program conducted June 7-11, 2010 by the Safe States Alliance (formerly the State and Territorial Injury Prevention Directors Association).

State Health Problem:

Health Burden:
Injuries are a serious public health problem in Indiana. Injuries often result in trauma, possible lifelong disabilities, or even death. In Indiana, unintentional injury is the leading cause of death among persons 1 to 34 years of age and the fifth leading cause of death overall following heart disease, cancer, stroke, and chronic lower respiratory disease. Fatality rates and hospitalization rates are highest among persons over the age of 75. In addition, injury fatalities caused by intentional acts, such as homicide or suicide were among the top four causes of death in Indiana in all age groups from age 5 to 54. Unfortunately, Indiana has lacked the resources to support a program devoted to injury prevention.

Target Population:
Number: 6,000,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 1,200,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: U.S. Census Bureau

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $100,000
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Start-up
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
75-99% - Primary source of funding

ESSENTIAL SERVICES – OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 9 – Evaluate health programs

Objective 1:
Establish Injury Prevention Program
Between 01/2011 and 12/2011, State will develop **1** comprehensive injury and violence prevention program.

Annual Activities:
1. Hire a director
Between 01/2011 and 12/2011, Hire a director to lead a new division at the ISDH for Injury and Violence Prevention.

State Program Title: Office of Women's Health

State Program Strategy:

Program goals: Goal 1: Utilize and Share Gender-Focused Data
Strategy 1.1: Identify and monitor key data measures for Indiana women
Strategy 1.2: Identify and share current gender-focused research
Strategy 1.3: Create and distribute Indiana Women's Health Data Sheets

Goal 2: Expand Infrastructure in Order to Enhance OWH Capacity
Strategy 2.1: Appoint OWH staff person to be the lead for each healthy behavior and provide training that equips them to serve as subject matter experts on gender disparities
Strategy 2.2: Identify and pursue at least one major grant or fundraiser each year to fill an identified gap
Strategy 2.3: Restructure the OWH Advisory Board to align with the five year focus

Goal 3: Support Policy Development and Environmental Change
Strategy 3.1: Research, prepare, and disseminate a summary of gender-focused policy
Strategy 3.2: Identify and provide appropriate support for at least one priority policy issue annually
Strategy 3.3: Assess needs and provide training resources for evidence-based organizational level policies

Goal 4: Collaborate with Internal and External Partners to Infuse Gender-Based Strategies with Statewide Activities and Mobilize Communities to Provide Local Level Support
Strategy 4.1: Actively participate with internal and external groups addressing healthy behaviors at a state level
Strategy 4.2: Organize a network of female leaders across the state to carry out local level action that supports policy and environmental change

Health Priorities: The leading causes of mortality, chronic disease, and infectious disease in women. Other women's health issues.
Primary Strategic Partners:

State Program Setting:
State health department

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Program Director
State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 1
Total FTEs Funded: 1.00

National Health Objective: HO 23-17 Population-based prevention research

State Health Objective(s):

Between 01/2011 and 12/2011, expand the infrastructure of the Office of Women's Health at the Indiana State Department of Health.

Baseline:
Office currently only staffs 1 person to lead the office.

Data Source:
ISDH budget information

State Health Problem:

Health Burden:
The leading causes of death in Indiana reflect that of national patterns. One hundred years ago the leading causes of death were infectious disease, such as pneumonia, tuberculosis, diarrhea, diphtheria and so on. In contrast, the leading causes of death in the United States in 2006 were chronic conditions such as heart disease, cancer and stroke.

Leading causes of mortality among women in Indiana

Source: Indiana Mortality Report, ISDH, Indiana 2006

Cardiovascular disease (CVD), including heart disease and stroke, is the number one cause of death among women in Indiana. Diseases of the heart are the leading cause of death for all racial and ethnic groups. Incidence rates are not reportable so estimates of incidence are based on the number of deaths reported. For 2006, 7,191 women died from heart disease for a rate of 173.8 and 7,105 men in Indiana died from heart disease for a rate of 271.1. The mortality rates for black females were 217.9 while that in white females was 172.0. Heart disease was the leading cause of death among women 65 years and older.

The prevalence of heart disease is on the rise among women in Indiana. For 2008, the prevalence of coronary heart disease among women was 4.1% and in men was 5.8%. The prevalence of heart attacks was 3.4% among women and 6.7% among men. The prevalence of heart disease among white non-Hispanic women (4.1%) exceeded Hispanic women (3.7%) and black non-Hispanic women (3.4%). (The difference is not statistically significant). The prevalence of heart attacks among black non-Hispanic females (5.7%) exceeded white non-Hispanic females (3.3%) and Hispanic females (2.5%). (The difference is not statistically significant). The prevalence of coronary heart disease was highest among women 65 years and older (13.1%). Though not statistically significant, the prevalence of coronary heart disease and heart attacks among women in Indiana was greater than the prevalence among women in the United States (3.4%).

Heart disease was the second leading cause of hospitalization (pregnancy and childbirth being the first) for women in Indiana. For 2007, the number of discharges associated with heart diseases among women was 35,656. Out of these, the number of discharges associated with ischemic heart disease was 13,068, heart failure was 10,485, and conduction disorders along with disrhythmias were 7,800.

Risk factors for cardiovascular disease in women include: smoking, high blood cholesterol (low-density lipoprotein or LDL) levels, high blood pressure, physical inactivity, being overweight, poor nutrition, having diabetes, aging, heredity and genetic history, history of previous heart attack, birth control use by women who smoke or have high blood pressure, menopause, and excessive drinking.

Cancer (malignant neoplasms) is the second leading cause of death among women in Indiana. In 2006, 6,167 women died from cancer for a rate of 165.6 and 6,705 men died from cancer for a rate of 244.5. The mortality rates among black women (192.1) exceeded white women (165.6). Cancer was the leading cause of death for women 35-74. (Heart disease is the leading cause of death for ages 75 years and older).

In 2007, the number of Indiana women diagnosed with cancer was 13,941 for a rate of 403. The number of men diagnosed with cancer was 14,452 for a rate of 521.7. The incidence rates were highest among women 65 years and older.

Lung cancer is the leading cause of death among women in Indiana of all the cancers. Lung cancer exceeds breast cancer as a cause of death, despite women's greater fear of breast cancer. In 2006, 1,721 women died from lung cancer compared to 942 from breast cancer. The number of deaths from colon cancer was 593 and 558 for cancer of the lymphoid, haemotopoietic and related tissues.

In 2007, breast cancer had the highest incidence with a rate of 113.6. The incidence rates of breast cancer for white women (111.8) were similar to black women (115.6). The lung cancer incidence rate for women was 60.7. The lung cancer incidence rates for white women (59.9) were lower than the rate for black women (68.8). The female incidence rate for colon cancer was 31.5. The colon cancer incidence rates for black women (40.1) exceeded the rate for white women (29.9).

Cancer was the sixth leading cause of hospitalization among women in Indiana in 2007. The number of hospital discharges associated with cancer among women was 10,700. Out of these, the number of hospital discharges associated with colon cancer was 1,484, lung cancer was 1,393 and breast cancer was 968.

Stroke (cerebrovascular disease) is the third leading cause of death among women in Indiana. In 2006, women died from stroke at a rate of 47.4. Men had a stroke mortality rate of 49.4. The mortality rate for black women (56.4) exceeded the rate for white women (47.0). Stroke was the fourth leading cause of death among women 65 years and older.

For 2008, the prevalence of stroke among women in Indiana was 3.2% and 2.4% for men (the difference is not significant). The prevalence of stroke among black non-Hispanic females (7.1%) exceeded Hispanic females (3.4%) and white non-Hispanic females (3.1%). (The difference is not significant). The prevalence of stroke was highest among women 65 years and older (10.0%). The prevalence of stoke among women in Indiana was higher than the national average (2.7%). (The difference is not significant).

Chronic lower respiratory diseases (CLRD) and chronic obstructive pulmonary disease (COPD):
CLRD is the fourth leading cause of death among women in Indiana. In 2006, 1,695 women died from CLRD for a rate of 43.9. 1,585 men died from CLRD for a rate of 61.9. The mortality rate for white women (45.2) exceeded the rate for black women (29.6). CLRD was the third leading cause of death for women 55-74 years of age. **COPD** is the tenth leading cause of hospitalization among women in Indiana. In 2007, the number of hospital discharges associated with COPD among women in Indiana was 8,175.

Alzheimer's disease is the fifth leading cause of death among women in Indiana. In 2006, women died from Alzheimer's disease at a rate of 27.5. Men died at a rate of 20.3. The mortality rate among white women (28.1) exceeded black women (20.7).

Diabetes Mellitus is the sixth leading cause of death among women in Indiana. In 2006, 875 women died from diabetes mellitus for a rate of 22.8. Eight hundred and four men in Indiana died from diabetes for a rate of 29.8. The mortality rate for black women (40.9) exceeded the rate for white women (21.7). Diabetes mellitus was the fifth leading cause of death for women 55-64 years of age.

The prevalence of diabetes mellitus among women in Indiana is on the rise. In 2008, the prevalence of diabetes mellitus for women was 10.1% and 9.0% among men. The prevalence of diabetes among women in 2008 was significantly higher than the prevalence in 2004 (7.5%) and 2005 (7.8%). The prevalence of diabetes among black non-Hispanic females (17.8%) exceeded white non-Hispanic females (9.7%) and Hispanic females (5.9%). (The difference is not significant). The prevalence was highest among women 65 years and older (21.8%). The prevalence of diabetes among women in Indiana was greater than the national average (7.9%).

In 2008, 1.4% of women reported they had gestational diabetes (BRFSS). According to Indiana birth certificate data, in 2007 the percent of women with gestational diabetes giving birth was 4.5%. Out of these, 1.0% of women had diabetes prior to pregnancy.

Leading causes of infectious diseases among women in Indiana

Source: HIV/STD Program, ISDH, Indiana 2006

Chlamydia is the most common reportable infectious disease affecting women in Indiana. For 2007, the incidence rate for Chlamydia among women 20 years and older was 486.3. The incidence rate of Chlamydia among men 20 years and older in Indiana was 162.8. The incidence rate among black women (970.0) exceeded the rate for white women (108.1). The incidence of Chlamydia was highest among women age 20-24 years.

Gonorrhea is the second most common reportable infectious disease affecting women in Indiana. For 2007, the rate of incidence for Gonorrhea among women age 20 years and older was 152.5. The incidence rate of Gonorrhea among men age 20 years and older was 124.7. The incidence rate among black women (427.1) exceeded white women (23.3). The incidence of Gonorrhea was highest among women age 20-24 years.

Leading causes of hospital discharges among women in Indiana

Source: Hospitalization Data, ISDH, Indiana 2007

Influenza and Pneumonia is the third leading cause of hospitalization and the ninth leading cause of mortality among women in Indiana. For 2007, the number of hospitalizations associated with Influenza and Pneumonia was 12,218. For 2006, 565 women died from influenza and pneumonia for a rate of 13.6. Men in Indiana died at a rate of 22.7. The mortality rate among white women (13.7) exceeded the rate for black women (12.9).

Osteoarthritis is the fourth leading cause of hospitalization among women in Indiana. In 2007, the number of hospital discharges associated with osteoarthritis was 11,216.

In 2007, the prevalence of arthritis among women was 34.8% and 25.8% for men. The prevalence of arthritis among black women (38.2%) and white women (35.6%) was significantly higher than the prevalence for Hispanic women (16.8%). The prevalence of arthritis is highest among women 65 years and older (61.5%). (Osteoarthritis is the most common type of arthritis, but the data above includes all forms of arthritis).

Traumatic Fractures of Bones is the fifth leading cause of hospitalization among women in Indiana. For 2007, the number of hospital discharges associated with traumatic fractures of bones was 10,879.

Leading causes of emergency room (ER) visits among women in Indiana

Table 1: Ten leading causes of Emergency Room (ER) visits among women, Indiana, 2007

Symptoms	Number of visits	percentage
Symptoms involving respiratory system and other chest symptoms	62,171	6.43%
Other symptoms involving abdomen and pelvis	59,674	6.17%
Symptoms involving head and neck	33,193	3.43%
General symptoms	33,167	3.43%
Other unspecified disorders of the back	32,177	3.33%
Other disorders of urethra and urinary tract	27,990	2.89%
Sprain and strains of other unspecified parts of the back	25,698	2.66%
Symptoms involving digestive system	19,222	1.99%
Migraine	19,179	1.98%
Other unspecified disorders of the joints	17,442	1.80%

Selected Health Behaviors

Many health behaviors negatively affect women's health, such as smoking, overeating and poor nutrition, lack of exercise, binge and chronic drinking, and risky sexual behaviors.

Tobacco use is the single most preventable cause of death in the United States and constitutes serious and growing health risks for women in Indiana. Smoking is responsible for more than 9,800 premature deaths in Indiana annually, and close to 3,800 of these deaths occurs in women.

In Indiana, 26.0% of people age 18 and over were current smokers according to 2008 BRFSS data. Approximately 28.3% of adult men smoke, compared to 23.9% of adult women. Indiana exceeded the national average for smoking by women (16.5%). Almost 1 in 5 white (23.5%) and almost 1 in 3 black (30.0%) women smoke. Women in the 25-34 age groups have the highest percentage of smokers among adult women with 28.0%. Approximately 35.0% of women and 47.0% of men attempted to quit smoking in 2008.

In 2006, 17.3% of pregnant women in Indiana smoked, compared to the national average of 11.0%, making Indiana one of the highest among states for smoking during pregnancy.

Poor nutrition is related to both overeating and not eating enough healthy foods. For 2007, 5.8% of women in Indiana reported eating less than one serving of fruits and vegetables per day. Thirty-five percent of women eat more than one but less than three servings a day. Thirty-four percent of women eat more than three but less than five servings of fruits and vegetables per day and only 25.7% of women eat more than five servings.

Poor nutrition and unhealthy eating habits are key factors contributing to overweight and obesity. In 2008, 29.8% of Indiana women were considered overweight and 28.0% were considered obese based on body mass index calculated from self-reported height and weight. Obesity in turn is a leading risk factor of a number of chronic conditions including diabetes, heart disease, stroke, and so on. For Indiana adults with diabetes, 370,000 (86.3%) are overweight or obese.

Physical inactivity is another important risk factor contributing to overweight and obesity. Sedentary lifestyle is defined as getting little or no leisure-time physical activity or irregular activity. For 2007, 42.4% of women in Indiana reported insufficient moderate or vigorous physical activity as opposed to 36.9% of men. (The difference is not significant). Fourteen percent of women did not participate in any physical activity as compared to 11.4% of men. (The difference is not significant). Fourteen percent of women met both vigorous and moderate physical activity recommendations as compared to 21.6% of men. (The difference is statistically significant). It has been reported that 70.0% of women are involved in sedentary work and lead a sedentary lifestyle.

Alcohol abuse is classified as acute (binge) and chronic (heavy) drinking and is a serious health risk. Binge drinking is defined as the consumption of four or more alcoholic drinks for women and five or more alcoholic drinks for men on a single occasion. In 2008, 8.9% of women and 23.8% of men in Indiana reported binge drinking. Binge drinking occurs more among women 25-34 years of age as compared to women 55-64 years of age. Heavy drinking is defined as the consumption of more than one drink per day for women and two or more drinks per day for men. Three percent of women and 5.9% of men in Indiana were reported to be heavy drinkers in 2008.

Risky sexual behaviors are posing great challenges in the field of public health due to the chance of contracting a sexually transmitted disease (STD) or experiencing an unplanned pregnancy. In 2002, 8.9% of adults aged 15-44 years had participated in risky sexual behavior, increasing their risk of contracting HIV and STDs. Overall 10.2% of males and 7.6% of females were at risk for HIV associated with risky sexual behavior.

In 2004, 68.3% of adult women in Indiana reported they were doing something to keep from getting pregnant. Of those women, 15.3% reported that their spouse/partner used condoms as a birth control method. Twenty-percent of women had their tubes tied as a birth control method. Seventeen percent of women reported their spouse/partner had undergone sterilization. Thirty-percent of women used birth control pills and 15.4% of women used some other birth control method.

Target Population:
Number: 3,000,000
Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Community Based Organizations

Disparate Population:
Number: 500,000
Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Community Based Organizations

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

No Evidence Based Guideline/Best Practice Available

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $75,000
Total Prior Year Funds Allocated to Health Objective: $0

Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

ESSENTIAL SERVICES – OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 9 – Evaluate health programs

Objective 1:
Assess program needs
Between 01/2011 and 12/2011, State health department will identify **1** priority policy issue.

Annual Activities:
1. Hire program director
Between 01/2011 and 12/2011, The Office of Women's Health at the ISDH will hire a program director for the purpose of researching and identifying at least 1 priority policy issue to assess.

State Program Title: Oral Health Program

State Program Strategy:

Goal: Increase the number of children who have received dental sealants on their molar teeth through the IU School of Dentistry's program, SEAL INDIANA, which will provide leadership in creating satellite school-based sealant programs in counties that lie far outside Indianapolis. The program will work with a local health department, a community health center, and a regional campus of Indiana University to establish a program in these areas. The program will offer consultation and expertise to enable new programs to begin while SEAL INDIANA continues to provide services for children throughout the state.

Health Priorities: On average, 52% of Indiana children examined have untreated dental decay; 35% have non-urgent dental decay, and 17% have decay in urgent need of immediate follow-up, some including pain and/or infection. The quality of life and ability to concentrate in school are surely adversely affected for this 17% of children. SEAL INDIANA is targeting and reaching the population of children most in need of care.

Primary Strategic Partners: Indiana University School of Dentistry, local health departments, community health centers

Evaluation Methodology: Over the past six years, SEAL INDIANA has placed over 24,000 sealants on the permanent teeth of Indiana children from low-income families. Evidence-based research indicates that dental caries are effectively prevented by dental sealants, and therefore the Healthy People 2010 objectives state the goal of at least 50% of eight and fourteen year old children having sealants. Support of this program will allow for the placement of more sealants on the teeth of children, thus helping Indiana to make strides toward reaching this goal.

State Program Setting:

Community health center, Local health department, Schools or school district, University or college

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0
Total FTEs Funded: 0.00

National Health Objective: HO 21-8 Dental sealants

State Health Objective(s):

Between 01/2011 and 12/2011, Increase the number of children with dental sealants

Baseline:

Objective	**Increase in Children Receiving Dental Sealants on Their Molar Teeth**	**1988–94 Baseline**
		Percent
21-8a.	Children aged 8 years	23

21-8b.	Adolescents aged 14 years	15

Data Source:
National Health and Nutrition Examination Survey (NHANES), CDC, NCHS; Oral Health Survey of Native Americans, 1999, IHS; Hawai'i Children's Oral Health Assessment, 1999, State of Hawaii Department of Health.

State Health Problem:

Health Burden:
SEAL INDIANA has served over 17,000 children at over 800 Title I schools (lowest income), community health centers, Head Start programs, including those for children of migrant farm workers, and homeless shelters that house children. Among the children examined, on average, 52% have untreated dental decay; 35% have non-urgent dental decay, and 17% have decay in urgent need of immediate follow-up, some including pain and/or infection. The quality of life and ability to concentrate in schools are surely adversely affected for this 17% of the children.

Target Population:
Number: 2,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes

Disparate Population:
Number: 2,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: Indiana University School of Dentistry

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS; Oral Health Survey of Native Americans, 1999, IHS; Hawai'i Children's Oral Health Assessment, 1999, State of Hawaii Department of Health.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $75,000

Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $75,000
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

ESSENTIAL SERVICES – OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 7 – Link people to services

Objective 1:
Dental Sealants for Children
Between 01/2011 and 12/2011, Indiana University School of Dentistry will provide dental sealants to **2000** children.

Annual Activities:
1. SEAL INDIANA
Between 01/2011 and 12/2011, SEAL INDIANA has served over 20,000 children at over 1000 Title I schools (lowest income), community health centers, Head Start programs, including those for children of migrant farm workers, and homeless shelters that house children. Among the children examined, on average, 52% have untreated dental decay; 35% have non-urgent dental decay, and 17% have decay in urgent need of immediate follow-up, some including pain and/or infection. The quality of life and ability to concentrate in schools are surely adversely affected for this 17% of the children.

The IU School of Dentistry's program, SEAL INDIANA, will provide leadership in creating satellite school-based sealant programs in counties that lie far outside Indianapolis. The program will work with local health departments, community health centers, and a regional campus of Indiana University to establish programs in these areas. The program will offer consultation and expertise to enable new programs to begin while SEAL INDIANA continues to provide services for children throughout the state.

State Program Title: Public Health Performance Management

State Program Strategy:

Goal: To improve the overall quality and capabilities of Indiana's public health system. There will be a specific focus on the 10 public health essential services for the purposes of future voluntary accreditation for public health agencies.

Health Priorities: In order to improve the competencies of Indiana's Public Health Sector, it is important for all public health agencies to assess current competencies and subsequently work to improve identified weaknesses.

In FFY 2007, the Indiana State Department of Health (ISDH) was granted advance access to version 2 of the National Public Health Performance Standards Program (NPHPSP) assessment tool. This tool has currently already been used by several local health departments in Indiana, and a state public health assessment workshop was conducted in August of 2007. In FFY 2008, public health agencies that had already started this process continued their respective activities, while other agencies were invited to begin with the assessment phase.
In FFY 2009, all previous agencies continued their respective activities, and mentored other communities by sharing ideas and their best practices. Twenty new public health agencies began the assessment phase of the quality improvement project.

For FFY 2010 approximately 18 new public health agencies and the state lab system will begin the assessment phase of the quality improvement project. Governance assessments will be conducted with 5 boards of health, and 14 public health agencies that began the process in the past will complete a comprehensive evaluation. Agencies that underwent the assessment phase previously will continue respective activities.

For FFY 2011, approximately 20 new public health agencies will begin the Local Public Health System Assessment. Five new Local Public Health Governance Assessments will be conducted. Three public health agencies that have already completed the initial assessment have volunteered to repeat the assessment since their previous assessment is older than three years. Approximately 18 Local Public Health Systems will be trained in Lean Six Sigma Yellow Belt for Public Health Systems.

Strategic partners: Indiana Public Health Association, Purdue University, local health departments, public health laboratories

State Program Setting:

Local health department, State health department

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Director-Office of Public Health Performance Mgmt
State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 1
Total FTEs Funded: 1.00

National Health Objective: HO 23-8 Competencies for public health workers

State Health Objective(s):

Between 01/2011 and 12/2011, conduct competency assessment at 22 local health departments in Indiana. The assessments will be based on the 10 essential public health services.

Baseline:

A total of 55 of Indiana's 93 local health departments have completed the assessment process and many of these are continuing with project charter training and execution. The National Academy of Sciences' 2002 report on *The Future of the Public's Health in the 21st Century* cited figures released jointly by the CDC and the Agency for Toxic Substances and Disease Registry in 2001 which indicated that "80% of the current public health workforce lacks formal training in public health."

Data Source:

National Academy of Sciences

State Health Problem:

Health Burden:

The public health workforce in Indiana currently lacks many of the core competencies necessary to fully and positively impact the health of the populations they serve. While the majority are competent in their own individual duties, most are not competent in the 10 essential public health services and how their duties fit in to the overall provision of these services. This is not an issue that is unique to Indiana. The National Academy for Sciences' 2002 report on *The Future of the Public's Health in the 21st Century* cited figures released jointly by the CDC and the Agency for Toxic Substances and Disease Registry in 2001 which indicated that "80% of the current public health workforce lacks formal training in public health."

This lack of basic public health competencies is widespread. It is seen in both small, rural local health departments and in large, urban local health departments. The problem continues to worsen in many areas because new employees are often only trained in their day-to-day functions and are not provided with the big picture of public health. Subsequently, most public health agencies in Indiana do not operate at full efficiency.

Therefore, our target population is the workforce at a select number of local health departments in Indiana as well as the Indiana State Department of Health. This also includes members of local and states Boards of Health and other policy makers that have a role in determining the priorities of public health agencies, such as County Commissioners. In addition, the population includes the coalitions and partners that already participate in the state public health assessment process and will be part of the process to address needs and weaknesses as a result of that assesssment, as well as Health Care Delivery Organizations. The disparate population includes these same individuals, due to the fact that all bear a disproportionate burden as a result of the identified health burden.

Cost Burden

This lack of basic competencies within Indiana's public health workforce threatens to result in a reduced quality of life in the communities they serve. The failure to act to address these competencies could result in the inability to pursue future voluntary accreditation, and the potential benefits that could result from that accreditation, financial, and otherwise.

Target Population:

Number: 880
Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers

Disparate Population:
Number: 1
Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: National Public Health Performance Standards Program (NPHPSP)

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $644,030
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
75-99% - Primary source of funding

ESSENTIAL SERVICES – OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 3 – Inform and Educate

Objective 1:
Communication Improvement
Between 01/2011 and 12/2011, ISDH will increase the number of participants on the monthly LHD webcasts from 40 to **60**.

Annual Activities:
1. Surveys
Between 01/2011 and 12/2011, Analyze the current users of webcasts and receive feedback on how to improve viewership

Receive updated staff contact information on an annual basis

Train on the use of Sharepoint site.

2. Public Health Modernization
Between 01/2011 and 12/2011, Promote shared services between local health departments by educating personnel on public health modernization and providing resources as needed.

Essential Service 8 – Assure competent workforce

Objective 1:
Public Health System assessments

Between 01/2011 and 12/2011, Indiana State Department of Health and Contractors will identify **22** local public health agencies to address their needs and weaknesses.

Annual Activities:

1. Public Health System Assessments

Between 01/2011 and 12/2011, conduct assessments of local public health systems using the NPHPSP assessment instrument and follow-up with Lean Six Sigma Yellow Belt in Public Health training

2. Other System Assessments

Between 01/2011 and 12/2011, public health system assessments will be conducted as identified (i.e., environmental state-wide public health system).

Objective 2:

Provide access to educational resources and trainings

Between 01/2011 and 12/2011, ISDH and contractors will maintain **4** opportunities for education and/or training of the public health workforce.

Annual Activities:

1. Local health department trainings

Between 01/2011 and 12/2011, Continue conducting an annual conference for Public Health Nurses including providing CNEs.

Begin a health officer training program that has 2 live trainings per year and offers online training modules.

2. Support opportunities for education and training for agency staff

Between 01/2011 and 12/2011, Continue access to the virtual library and other web-based and print resources. Provide funding availability to staff for otherwise unfunded travel to educational and/or training conferences.

State Program Title: Sexual Assault Services

State Program Strategy:

Program Goal: To reduce the prevalence of rape and attempted rape of women age 12 and older.

Program Priorities: The Indiana Criminal Justice Institute (ICJI) oversees Indiana's Sexual Assault Services programs. Distribute Sexual Assault Services funds to various sub-grantee organizations throughout the state that provide services aimed at increasing and enhancing prevention, intervention, and treatment programs with the ultimate goal of reducing the prevalence of rape or attempted rape. Priorities will be placed on education programs specifically targeting the young adult and youth populations. The purpose of these programs is to link people to services as part of efforts to reduce the rate of sexual violence among young adults and youth.
Contracts with each sub-grantee will include the following deliverables:

- To show an increase in services or coverage to underserved areas.
- To show an increase in focus on the targeted populations.
- To enhance the dissemination of information on treatment for sex offenders in Indiana.
- To show an increase in the number of youth receiving education on issues of sexual violence.

Primary Strategic Partnership: The Indiana Criminal Justice Institute has fostered collaborative partnerships with 21 external organizations around the state that provide sexual assault services.

Role of PHHSBG Funds: PHHSBG funds will be used to provide direct funding for programs at organizations that provide sexual assault services.

Evaluation Methodology: Evaluations of each project shall be conducted on two levels. The first level of evaluation will be completed internally by the sub-grantee's agency director or through another internal control process of evaluation. The second level is conducted by ICJI with statistical data and other anecdotal information to allow for rigorous evaluation of each individual project as well as providing a means for overall evaluation of the SAS funding stream. ICJI and The Coalition against Sexual Assault will be working in a collaborative approach in regards to compliance monitoring for all grant funds awarded. Monthly reports will be required of each funded project. These reports are broken into the following categories:

- financial information to document accounting of SAS funding.
- statistical information to document sexual assault activities, programming efforts and victims served.
- narrative information to document attainment toward objectives.

Each organization that receives funding will also be required to establish its own mechanism of data collection and internal controls. The ICJI monthly reporting process establishes the guidelines and requires extensive data collection and maintenance information from each subgrantee organization.

State Program Setting:

Local health department, State health department

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0
Total FTEs Funded: 0.00

National Health Objective: HO 15-35 Rape or attempted rape

State Health Objective(s):

Between 01/2011 and 12/2011, Provide services to victims of sexual violence and provide education about prevention to the general public.

Baseline:
It is estimated that in Indiana there could be as many as 5,730 victims of rape annually based upon reports from the Federal Bureau of Investigation.

Data Source:
Uniform Crime Reports

State Health Problem:

Health Burden:
Indiana continues to deal with the serious problem of sexual violence. Each year more than 4,000 Indiana children are substantiated as victims of child sexual abuse according to Child Protective Services. In 2008, according to UCR data, 1,720 forcible rapes (completed and attempted) in Indiana were reported to law enforcement, for a rate of 27 per 100,000. Nationally in 2008 there were 89,000 rapes reported to UCR and 203,830 victims of rape (persons 12 and older) reported through the National Crime Victimization Survey. Of those victims 182,000 were women. Females ages 12-24 experienced the highest sexual assault victimization rates. Black females experienced higher rates of rape or sexual assault than white females or females of other races (2.9 compared to 1.2 and 0.9 per 1,000 females age 12 or older, respectively).

A recent study showed on average from 1992 through 2000, 31 percent of rapes and sexual assault were reported to police. More recently, the 2008 NCVS illustrated that 41% of rapes and sexual assaults were reported to police. A Bureau of Justice Statistics report on Female Victims of Violence found that almost half (47%) of the rapes or sexual assaults against women in 2008, were reported to the police. Using a 31% - 47% reporting rate, it can be estimated that 3,664 to 5,730 rapes could occur annually in Indiana.
The problem affects all races and income levels, but is more prominent in low-income, urban areas. The target population for this program includes all individuals who receive sexual assault treatment and prevention services from the selected sub-grantee organizations. The disparate population includes the more specific group of low-income individuals who receive this treatment.
According to the FBI, forcible rapes are at there lowest figure in the past 20 years. This is further backed up with the data from the NCVS which indicates rapes have been declining gradually since 1999. This is attributed to many factors: (1) improvements in the criminal justice system, including reform in how police gather evidence and better prosecution. (2) Advances in DNA can help identify the offender and lead to a higher chance of prosecution, keeping the offender from repeat attacks. (3) The creation of the federal Violence Against Women act in 1994 has helped bolster attention to rape cases and increased the number of professionals working to assist victims and (4) There as been an increase in awareness of rape and more educational public awareness campaigns that has helped shift attitudes about rape (RAINN). This trend can be furthered with the continuation of the educational programs developed through SAS programs. In recent years, the number of agencies that have established sexual assault prevention, treatment and intervention programs has increased significantly.

There continues to be problems of sexual violence in Indiana and the need for prevention, intervention, and treatment programs is ever pressing. With the continuation of funding from the Sexual Assault Services

grant, the number of sexual assaults can be further reduced with the overall goal of total eradication of sexual violence.

Target Population:
Number: 3,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 2,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: RAINN, NCVS

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Best Practice Initiative (U.S. Department of Health and Human Service)

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $148,899
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $148,899
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

ESSENTIAL SERVICES – OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 7 – Link people to services

Objective 1:
Provide services to victims, and provide information about prevention to all
Between 01/2011 and 12/2011, Indiana Criminal Justice Institute will provide services to **1000** victims of sexual violence.

Annual Activities:

1. Extend coordinated, comprehensive sexual violence prevention programs within counties
Between 01/2011 and 12/2011, the programs would

- Educate youth about the role of drugs and alcohol in sexual violence.
- Encourage underserved regions and counties to develop a prevention curriculum.
- Encourage communities to provide programs in environments that will teach males as well as females.

2. Expand coordinated, comprehensive sexual offender treatment programs with the state
Between 01/2011 and 12/2011, the programs would

- Disseminate informational materials on effective treatment programs in Indiana.
- Increase services to underserved regions, specifically in the Northwest and West Central regions of Indiana.
- Expand collaborative efforts with correctional re-entry programs targeting servies for domestic violence offenders.

ICJI will also work the other state level partners to increase the percentage of prevention programming throughout the state.

3. Improve and enhance services and response initiatives to victims of sexual assault.
Between 01/2011 and 12/2011, the programs would

- Encourage and support current efforts to provide services through crisis intervention, hotlines, support groups, and other services.
- Encourage expansion of services and support to underserved counties.
- Encourage services with correctional re-entry programs targeting family preservation for victims of sexual violence.

State Program Title: State Health Data Center

State Program Strategy:

Program Goal: To increase the quality and quantity of data collected by the Indiana State Department of Health.

Program Priorities: With previous PHHS Block Grant funds, the State Health Data Center at the Indiana State Department of Health (ISDH) has improved the use of data with an end result of overall improvement in public health access to information and surveillance data. The agency would like to continue this work and increase the amounts and types of data acquired.

Primary Strategic Partners: The ISDH has fostered collaborative relationships and strategic partnerships both internally and externally. They include:

Internal:	**External:**
Data Analysis Division	Indiana Health Information Exchange
Epidemiology Resource Center	Local Health Departments
ISDH Laboratory	Multiple labs
Preparedness division	Indiana Women's Prison
STD division	Indiana Juvenile Facility
Maternal and Child Health division	Southern Indiana Pediatrics
Food protection division	Indiana Restaurant and Hospitality Association
Environmental Health division	Indiana Grocers and Convenience Store Association
Information technology division	Indiana Dept. of Environmental Management
Acute Care Services division	Indiana Department of Natural Resources
Cancer Registry program	Clearwater Research

Evaluation Methodology: Increased quantity and quality of data collected by the agency.

State Program Setting:

Local health department, State health department

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0
Total FTEs Funded: 0.00

National Health Objective: HO 23-2 Public health access to information and surveillance data

State Health Objective(s):

Between 01/2011 and 12/2011, Increase the quantity and quality of public health data.

Baseline:
Improvements will be made to increase the amount and types of data collected.

Data Source:
Indiana State Department of Health

State Health Problem:

Health Burden:
In order to continue to improve the public health of Indiana's citizens, more and better data is needed to identify target populations with public health needs. Without this data populations with public health issues may be missed and opportunities to support those populations will not be available. Examples of these problems are as follows:

The OMPP Neonatal Quality Strategy Subcommittee has chosen PNCC as one of two strategies to be addressed in 2009-2010. The MCH Perinatal consultant sits on the OMPP Neonatal Quality Strategy Subcommittee. MCH, Office of Medicaid Policy and Planning, and the Managed Care organizations are collaborating to develop a seamless case management system for improved delivery of services to pregnant women. An important piece of this project standardized data collection. A means of collecting this data in a timely manner is imperative.
Prenatal Care Coordination (PNCC) in Indiana is provided by certified prenatal care coordinators in the home according to the Medicaid rule, by all three managed care organizations by telephone, by Healthy Families, and HIV coordinators. Each program is using different forms, guidelines, and data collection. The MCH Perinatal Consultant has revised the data collection Outcome Report for the ISDH PNCC program that will also be used by other care coordination programs to provide standardized data collection, quality assurance and comparison of outcomes among various programs. Currently, ISDH PNCC completes the Outcome Report by hand and submitted it to EDS or the MCO with billing forms. Outcome report forms are then sent to the Perinatal Consultant. An excel datasheet has been developed by the consultant to enter outcome report forms but this is not working due to lack of staff and time.

In order to maximize the effectiveness of Indiana’s food safety inspection officers (FSIO) data must be collected and analyzed to make effective use of valuable and limited resources and provide the most protection to the public. Currently, Indiana does not have a central data warehouse of food establishment information. Any data systems are housed, either in paper or electronic form, throughout all of the state and local jurisdictions with no connectivity of the data between agencies. It is not known how many food establishments exist in the state, let alone having any complete demographic data to characterize the type and scope of the operations. The second goal, and most likely the more important, is having the FSIO inspection data for each establishment in a system where food safety problems and trends could be identified. With this ability the regulatory authority could target its limited resources toward reducing or eliminating a food safety problem. Foodborne disease outbreaks continue to occur in the US with many deaths and hospitalizations each year.

Chlamydia and gonorrhea are some of the most commonly reported communicable diseases of any type in the U.S. and Indiana. Both are sexually transmitted infections easily diagnosed with lab testing and easily cured with antibiotics. These infections disproportionately affect youth under age 25 and gonorrhea especially affects African-Americans both in the U.S. and Indiana. Funding for these target groups is limited to certain locations such as Title X family planning clinics and certain STD clinics. Expansion of testing needs to occur in other facilities where these at-risk populations exist to better identify and then treat those afflicted with these diseases and to prevent the further transmission of communicable disease.

Target Population:

Number: 600,000
Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Disease Surveillance - High Risk, Community Based Organizations, Health Care Systems, Research and Educational Institutions, Business and Merchants

Disparate Population:
Number: 1
Infrastructure Groups: State and Local Health Departments, Disease Surveillance - High Risk, Community Based Organizations

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: FDA Model Food Code (latest version)
FDA Retail Food Risk Factors and Interventions
FDA Retail Food Safety Baseline Survey
FDA Retail Food Program Standards
FDA Manufactured Food Program Standards

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $200,000
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

ESSENTIAL SERVICES – OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Essential Service 1 – Monitor health status

Objective 1:
Improve the agency data collection system
Between 01/2011 and 12/2011, Indiana State Department of Health Software Developers, IT contractors will maintain **1** health information exchange system.

Annual Activities:
1. Clinical Health Information Messaging Exchange (CHIME)
Between 01/2011 and 12/2011, The overarching focus of CHIME is to streamline data collection efforts and make the best use of the public and private data flows currently available.This initiative will seek to expand beyond the reporting of disease-related lab results into a wider set of processes within the ISDH. Additionally, the CHIME initiative will explore new and innovative ways to enable bi-directional exchange in an efficient manner.

2. Obtain data sets

Between 01/2011 and 12/2011, add prevalance data to BRFSS and continue development of databases with the goal of obtaining additional public health data.

3. Continue development of epidemiological support
Between 01/2011 and 12/2011, support the development of the epidemiological resource center by providing resources as needed.

Objective 2:
Increase the quantity of data
Between 01/2011 and 12/2011, ISDH and contractors will increase the number of state surveys in BRFSS from 9200 to **11,000**.

Annual Activities:
1. Obtain additional prevalence data
Between 01/2011 and 12/2011, expand Indiana's BRFSS survey by increasing the number of surveys in a designated region.